# Four Situations Where The TC Code is Used.....

## Independent Living consumer enters the nursing home for a temporary stay.

### Unmet Spenddown:

Is the unmet portion of the spenddown less than the consumer's cost of care for the temporary stay at the nursing facility?

- If yes, then you can approve payment for the temporary stay.
    1. The unmet portion of the spenddown becomes the patient liability.
    2. The medical card is authorized by putting the 'Y' in the "cost of care > spenddown" field or by entering the nursing home charges on MEEX (depending on what kind of expenses have been used already to meet a portion of the spenddown).
    3. Payment is approved on LOTC.
    4. The 'TC' code is used with the appropriate nursing facility level of care effective the day the consumer entered the facility. .

- If no, then payment cannot be authorized for the temporary stay until the spenddown is met.
    1. No changes are made to LOTC.
    2. The consumer can chose to use adult care home charges to meet a portion of their spenddown. Remember NF charges are one of the four items that can be allowed on MEEX for a Medically Needy spenddown case.

### Spenddown Met:

- The base period remains intact.
- LOTC is coded for payment.
- The 'TC' code is used with the appropriate nursing facility level of care effective the date the consumer entered the facility.
- The client obligation for the temporary stay will be $0.00 (since the consumer's spenddown was already met).

## An HCBS consumer enters the nursing home for a temporary stay.

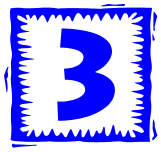
**RESPONSIBILITIES:**

- The HCBS case manager is responsible for sending the ES-3161 whenever they become aware of a consumer entering a nursing facility. The ES-3161 should indicate which facility they entered and the expected length of stay.
- The nursing facility is responsible for sending the MS-2126 form requesting Medicaid payment, indicating the admission date, and identifying the expected length of stay.
- Should the EES worker discover the consumer entered a nursing facility they are responsible for communicating with the HCBS case manager to determine the expected length of stay.

*Note: If there is a discrepancy in the length of stay the EES worker should always work with the case manager to resolve the situation. It is important that the correct coding is used if the case manager has planned on continuing waivered services while the consumer is in the nursing facility.*

**CODING A TEMPORARY STAY FOR HCBS CONSUMERS:**

- On LOTC change the 'HC' to 'TC' effective the date the consumer entered the nursing facility.
- The level of care remains the HCBS waiver code (FE, PD, etc.)
- Enter the effective date of payment
- If the consumer has an HCBS obligation it remains on the liability field and will continue to be assigned to the HCBS provider. There are no overpayments if the HCBS cost of care does not exceed the obligation while a person is on a temporary stay. MMIS does not deduct the liability from the nursing home's claim as long as there is an HCBS level of care on the LOTC screen.
- Set a WOAL to make sure the 'TC' coding does not go beyond the month of entrance and the following two months. It is the worker's responsibility to make sure the coding is changed and that LOTC returns to HCBS or the case is converted to nursing home budgeting with a liability when the temporary stay ends.



## HCBS consumer enters the nursing home for an indefinite length of stay.

**WHEN AN HCBS CONSUMER INDEFINITELY ENTERS THE NURSING FACILITY:**

**Step One**

- The 'TC' code should be entered on the LOTC screen for the first day of the nursing facility stay.
- You must change the patient liability to $0.00 effective the first day of the nursing facility stay, if it is not that already.
- Enter the effective date of payment.
- The HCBS level of care remains in effect that first day. This is necessary for the HCBS providers who may have provided services that day to bill.

**Step Two**

- The 'TC' code is replaced with the 'NF' code the second day of the consumer's nursing facility stay.
- The obligation remains $0.00 for the first month of the consumer's stay.
- The appropriate nursing facility level of care is entered effective the second day of the consumer's stay.
- The appropriate consumer, facility, and case manager notices should be sent.

**Step Three**

- The case is converted to nursing home budgeting the month following the month of entrance by adding the 'AC' to SEPA and giving the consumer the $62.00 protected income limit.
- The new patient liability is determined and entered on the LOTC screen.
- The appropriate consumer and facility notices should be sent.

## A Working Healthy consumer enters the nursing home for a temporary stay.

### Step One

- The case remains budgeted for Working Healthy
- LOTC is coded for nursing facility payment using the 'NF' living arrangement, the appropriate nursing home level of care ('SN' most common), and the effective date is the day the consumer entered the facility. If this is a WORK participant, you will still code NF/SN effective date of admission as there is no TC coding for Working Healthy.
- The consumer will not have a liability for the month they enter as they are responsible for any Working Healthy premium they may owe for the month of entrance.
- A WOAL is set to make sure the consumer receives a CARE assessment if the stay is expected to last longer than 30 days.
- A WOAL is set to make sure the consumer leaves the facility no later than two months after the month of entrance.

### Step Two

- Generally entering the nursing home means that the consumer will have a decrease in their earned income. The worker should react to the decrease the month after the month it is reported since Working Healthy uses one month base periods.
- The worker redetermines the premium obligation for the following month based on the decreased earnings of the consumer due to their nursing facility stay.

### Step Three

- The worker follows up on the alerts that they have set in Step One


# THE 'TC' CODE IS NOT USED WHEN A CONSUMER LEAVES A NURSING FACILITY AND GOES INTO AN HCBS ARRANGEMENT!

- When a nursing facility consumer expresses interest in HCBS services the ES-3160 must be sent to the appropriate organization to assess the consumer's situation.
- During discharge planning the plan of care can be input on the MMIS, but cannot be submitted for approval because the appropriate codes are not in place. The case manager needs to communicate with the waiver manager for approval of the plan of care.
- The ES-3160 is received once a consumer is discharged from the nursing home.
- The EES worker completes the LOTC screen and approves HCBS services. YOU NEVER USE AN EFFECTIVE DATE PRIOR TO THE DATE OF DISCHARGE!
- If the case manager provided billable services during discharge planning they can submit these to the waiver manager for consideration of payment. It may be necessary to have such services prior authorized so discussion with the case manager and the waiver manager is crucial.